marathon health
Better healthcare, closer to home

Homelessness Health Support Team referral form

Thank you for referring your participant. To help us understand your participant's needs, please complete all sections of this referral form.

Date of referral:	Referrer name:	Referrer phone:
Referrer email:	Referrer's relationship to participant:	

Participant details			
Title:	Family name:	First name:	Middle name:
Gender:	Date of Birth:	Estimated Date of Birth:	
Address or rough sleeping/Location:		Suburb:	
Postcode:	Phone:	Best contact method:	
Country of Birth:		Preferred language:	
Aboriginal and/or Torres Strait Islander: ☐ Yes ☐ No ☐ Unsure		Interpreter required: ☐ Yes ☐ No ☐ Unknown	
Is the participant a person with disability: ☐ Yes ☐ No ☐ Unsure		If yes, what is the nature of their disability:	
Smoking status:			

Emergency contact		
Name:	Relationship:	Phone:

Referral details
Health concerns?
Current professionals involved (GP, specialists, support services etc.)?
Has the participant undergone a RAS or ACAT assessment? ☐ Yes ☐ No ☐ Pending ☐ Unsure
Current accommodation arrangements? ☐ Homeless/Rough sleeping ☐ Unstable/Temporary housing ☐ Risk of eviction

Does the participant experience one or more of the following challenges?	
Isolation or no available support person	☐ Yes ☐ No ☐ Unsure
Communication barriers, including limited health literacy skills	☐ Yes ☐ No ☐ Unsure
Difficulty processing information to make decisions	☐ Yes ☐ No ☐ Unsure
Resistance or hesitancy to engage with aged care, institutions, or government for any reason	☐ Yes ☐ No ☐ Unsure
Their safety is at risk, or they may end up in a crisis	☐ Yes ☐ No ☐ Unsure
Please provide any relevant information that can assist us in supporting your participant in the most appropriate manner, and outline any barriers to accessing supports, any risks and outstanding health care needs or concerns:	

Consent

I consent to the referral being made on my behalf

Participant name	**Participant signature**	**Date**
Referrer name	**Referrer signature**	**Date**

Marathon Health is committed to protecting your information, and any information we collect is used to facilitate the services we provide to you.

- In providing high-quality services, we collect personal health information and maintain a participant record.
- We follow the Australian Privacy Principles (APPs) contained in the Privacy Act 1988 when handling, using and managing personal information.
- The APPs also outline your rights relating to accessing or correcting your personal information.
- We will not sell, transfer, assign or rent your information to any third party without your permission, unless required by law.

Referrer acknowledgement

I have discussed the proposed referral to a health professional with the participant and/or authorised representative and am satisfied that the participant and/or authorised representative understands the proposed collection, use and disclosure of personal health information and has provided informed consent to the proposed collection, use and disclosure.

Referrer name	**Referrer signature**	**Date**

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